cardiologists. Eighty-five percent of investigators were affiliated with hospitals with over 101 beds. Sixty-five percent and 72% of sites were public and teaching hospitals, respectively. We found significant variation among physician/site characteristics across geographic regions. Sixteen percent of US respondents were cardiologists, 52% in Latin America, 26% in Eastern Europe, 7% in Europe, 4% in Africa and Asia Pacific, and 0% in Canada (p = <.0001). Twenty-nine percent of US investigators were affiliated with public hospitals as compared to 100% in Canada, 97% in Eastern Europe, 88% in Europe, 87% in Asia Pacific, 53% in Latin America, and 22% in Africa (p = <.0001). CONCLUSION: We assessed physician/site characteristics in a clinical trial setting and determined that characteristics vary by geographic region. Therefore, it is important to measure physician and site characteristics to avoid the potential for confounding in the economic evaluation of the NAVIGATOR trial.

FACTORS INFLUENCING THE DIAGNOSTIC TESTS PRESCRIBING FOR TYPE 2 DIABETES IN AMBULATORY PATIENTS
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OBJECTIVES: Type 2 Diabetes is associated with severe complications such as heart disease, stroke, high blood pressure, kidney disease etc. Approximately 17 million people suffer from diabetes accounting to 6.2% of the population in the United States. According to the American Diabetes Association, the total cost of diabetes to the society is 98 billion dollars. Type 2 diabetes accounts for about 90–95% of all the diagnosed cases of diabetes. This study examines the various physician and patient factors, which influence the diagnostic test prescribing for diabetes in ambulatory patients. METHODS: Patient factors such as age, sex, race, geographical location and payment source and Physician factors such as specialty, geographic location and referral status were used to determine their influence on the number of diagnostic tests prescribed. Data from the National Ambulatory Medical Care Survey (NAMCS) 2000 were utilized. Patients with principal diagnosis of type 2 diabetes (ICD-9-CM code 250.00) were analyzed using multiple linear and binomial logit regression models. RESULTS: The numbers of diagnostic tests performed were independent of patients’ age, sex and geographic region (R2 = 0.117). Blacks and Hispanic patients were prescribed more diagnostic tests compared to other races (R2 = 0.346). Patients with Federal source of payments (Medicaid and Medicare) were prescribed more diagnostic tests than other patients (R2 = 0.245). Numbers of diagnostic tests were not influenced by whether the patient was referred (R2 = 0.037). Various physician specialties also had no influence on the number of diagnostic tests prescribed (R2 = 0.054). CONCLUSIONS: The numbers of diagnostic tests prescribed are significantly influenced by patients’ race and source of payments. Diagnostic tests constitute a significant portion of the cost of diabetes therapy. Further research, reviewing the causes of the significant differences seen in this study would help control/reduce the cost of diabetes therapy.

COST ANALYSIS OF DIABETES TREATMENT WITH GLARGINE INSULIN OR NPH INSULIN IN SPAIN
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OBJECTIVES: A pharmacoeconomic analysis was carried out comparing a long-acting analog of human insulin, insulin glargine (once-daily injection), and NPH human insulin (twice-daily injections) in patients with Type 1 (DM1) and Type 2 (DM2) diabetes mellitus in Spain. METHODS: Retrospective analysis using a cost-offset model, from the perspective of the National Health System in Spain. The following short term (1 year) health costs of diabetes mellitus were used in the model: glargine or NPH insulin treatment, use of lispro insulin, nurse home visits, severe hypoglycemia episodes, test strips for glucose control and disposable needles. The utilisation of resources was estimated from two clinical trials comparing insulin glargine (Lantus) and NPH human insulin in patients with DM1 and DM2 and from Spanish sources, and the unit costs from a Spanish health costs database. RESULTS: The use of glargine insulin instead of NPH insulin would result in an annual saving of €234.75 and €89.47 for a patient with DM1 and DM2, respectively. Although the acquisition cost of glargine insulin is higher, yearly savings can be achieved compared to NPH insulin in the remaining costs analysed especially in the use of less test strips (€198.85 in DM1 and DM2), less costs in nurse home visits (€83.22 in DM1 and DM2), lower doses of lispro insulin (€49.78 in DM1), lower incidence of severe hypoglycemia (€6.91 and €1.33 in DM1 and DM2) and lower costs in insulin needles (5.02 euros in DM1 and DM2). CONCLUSIONS: A comprehensive analysis of the costs associated with insulin treatment shows that switching to once-daily insulin glargine from NPH insulin reduces Health System costs for treating Type 1 and Type 2 diabetic patients in Spain.

DIABETES—Quality of Life/Preference Based Outcomes

EVALUATION OF QUALITY OF LIFE IN PATIENTS WITH NEUROPATHY USING THE NORFOLK QUALITY OF LIFE (QOL) TOOL
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OBJECTIVE: Our objective was to examine the scores and reproducibility of a 47 item Quality Of Life ques-